Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: R. Stumhoffer, DO 7502 Greenville Ave., Ste. 600 Dallas, TX 75231	MFDR Tracking #: M4-08-0885-01 DWC Claim #: [redacted] Injured [redacted]
Respondent Name and Box #: City of Houston Rep. Box # 42	Date of [redacted] Employer [redacted] Insurance Can[redacted]

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "MMI/IR exam (ROM)."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Amount Sought $650.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: None submitted.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Denial Codes	Part V Reference	Amount Due
10-16-06	99456-WP Evaluation for MMI/IR	D19	1-6	$650.00
Total Due:				$650.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003.

1. These services were denied by the Respondent with reason code "D19-Claim/Service missing supporting documents." The Requestor submitted a copy of the evaluation report; therefore, the disputed service will be reviewed per Rule 134.202.

2. According to Rule 134.202(e)(6)(C)(iii), "An examining doctor, other than the treating doctor, shall bill using the 'Work related or medical disability examination by other than the treating physician....' CPT code. Reimbursement shall be $350."

3. According to Rule 134.202(e)(6)(D)(II), "The MAR for musculoskeletal body areas shall be as follows.

a) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th Edition is used.
b) If full physical evaluation, with range of motion is performed:
   1) $300 for the first musculoskeletal body area; and
   2) $150 for each additional musculoskeletal body area.

4. According to Rule 134.202(e)(6)(D)(III), "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with the modifier "WP." Reimbursement shall be 100% of the total MAR."

5. Advisory 2004-01, issued on March 25, 2004, stated in part that, "an IR by the DRE method or injury model, this type of IR is reimbursed at $150 per DRE area. Both of the above fees are reimbursed in addition to the $350 paid for the MMI evaluation."

6. On this date, the Requestor billed $500.00 for CPT code 99456-WP. Per Advisory 2004-01, the Requestor correctly coded the MMI and IR evaluation using CPT code 99456-WP. Per Rule 134.202(e)(6)(C)(iii), the Requestor is entitled to reimbursement of $350.00 for MMI evaluation. In addition, Rule 134.202(e)(6)(D)(II)(b) allows reimbursement of $300.00 for IR for the first musculoskeletal body area. Therefore, the Requestor is entitled to reimbursement of $350.00 + $300.00 = $650.00. The insurance carrier paid $00.00. The Requestor is entitled to the difference between amount paid and due, which equals $650.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Advisory 2004-01
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $650.00 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER / DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	[redacted]	4-11-08

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.